**Summary of the CON Task Force Public Forum**

**June 7, 2005**

**Maryland Health Care Commission**
**4160 Patterson Avenue**
**Baltimore, Maryland 21215**

## Task Force Members and Commissioners Present

Commission Chairman Stephen J. Salamon
Commissioner Robert E. Nicolay, Task Force Chairman
Commissioner Larry Ginsburg
Commissioner Robert Moffit, Ph.D.
Alan Bedrick, M.D.
Albert L. Blumberg, M.D., F.A.C.R.
Lynn Bonde
Patricia M.C. Brown, Esquire
William L. Chester, M.D.
Annice Cody
Hal Cohen
Natalie Holland
Carlessia A. Hussein, DrPH
Michelle Mahan
Henry Meilman, M.D.
Anil K. Narang, D.O.
Lawrence Pinkner, M.D.
Frank Pommett, Jr.
Barry F. Rosen, Esquire
Christine M. Stefanides, RN, CHE
Joel Suldan, Esquire
Jack Tranter, Esquire
Terri Twilley, MS, RN
Douglas H. Wilson, Ph.D.

## Task Force Members Absent

Adam Kane, Esquire

## Public Testimony

Erwin Abrams, Hospice Network of Maryland
Mara Benner, Maryland National Capital Homecare Association
Thomas Firey, Maryland Public Policy Institute
Sean Flanagan, St. Joseph Medical Center
Andrea Hyatt, Maryland Ambulatory Surgical Association
Donna Jacobs, University of Maryland Medical Systems
Deron Johnson, Maryland Ambulatory Surgical Association
Robert Johnson, Jewish Social Service Agency
Danna Kauffman, Mid-Atlantic LifeSpan
Lawrence Merlis, President and CEO, Greater Baltimore Medical Center
Frank Monius, Maryland Hospital Association
Sam Moskowitz, Mercy Health Services
Cal Pierson, President, Maryland Hospital Association
Nicole Price, SEIU, District 1199 E-DC
Andrew Solberg, A.L.S. Healthcare Consultant Services
Howard Sollins, Health Facilities Association of Maryland
Sue Ellen Stuart, Gentiva Health Services
Elizabeth Weglein, Maryland National Capital Home Care Association

## Members of the Public Present

Vanessa Aburn, Union Memorial Hospital
Regina Bodnar, Greater Baltimore Medical Center
Clarence Brewton, MedStar Health
Amy Carle, Maryland Ambulatory Surgical Association
Andrew Cohen, AGC and Associates
Miles Cole, Maryland Department of Business and Economic Development
Karlene Conrad, Community Hospices
Richard Coughlan, Cohen, Rutherford + Knight
Sylonda Davis, University of Maryland Medical Center
Ron DeCesare, Professional Healthcare Resources
Jack Eller, Esquire, Ober, Kaler, Grimes, & Shriver
Sean Flanagan, St. Joseph Medical Center
Craig Flury, Flury & Associates, Inc.
Greg Floberg, Hospice of Charles County
Valerie Fox, Stella Maris
Myrtle R. Gomez, Nursing Enterprises
Bruce Goodman, Community Home Health of Maryland
Christopher Hall, Adventist Healthcare
James Hamill, Washington County Health System
Marie Harkowa, Shore Home Care Hospice
Wynee Hawk, Greater Baltimore Medical Center
James Hursey, Greater Baltimore Medical Center
Donna Jacobs, University of Maryland Medical System

Deron Johnson, Law Office of J. William Pitcher
Brian Kahan
Danna Kauffman, Mid-Atlantic LifeSpan
Eileen Lacijan, Hospice of Queen Anne's
Anne Langley, Johns Hopkins Health System
Angela Lavin, Funk & Bolton, P.A
Richard McAlee, Esquire, Southern Maryland Hospital
Michael S. McHale, Community Hospices
Shawn McNamara, Upper Chesapeake/St. Joe's Home Care
Denise Matricciani, Maryland Hospital Association
Lawrence Merlis, Greater Baltimore Medical Center
Joe Meyers, St. Agnes Health Care
Amy Millar
Ann Mitchell, Montgomery Hospice
Frank Monius, Maryland Hospital Association
Sam Moskowitz, Mercy Health Services
Alice Neily, Hospice Network of Maryland
Nicole Price, SEIU, District 1199 E-DC
Vanessa Purnell, MedStar Health
Barbara Ray, Hospice Caring, Inc.
Debbie Reeder, Chester River Home Care and Hospice, Hospice Network of Maryland
Cori Rehus, St. Agnes Health Care
Laura Resh, Carroll Hospital Center
Michele Rice, Potomac Home Health Care
Bill Salganik, Baltimore Sun
Sue Lyn Schramm, Montgomery Hospices
Rajesh Shah, Harvard University Law School
Robin Shaivitz, Alexander & Cleaver
Eric Slechter, Franklin Square Hospital
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Sue Ellen Stuart, Gentiva Health Services
Judy Weiland, Mercy Health Services
Paula S. Widerlite, Adventist HealthCare
Georgia Wilkison, Hospice of Queen Anne's

## 1. Call to Order and Introductory Remarks

Chairman Robert E. Nicolay called the meeting to order at 10:12 a.m., welcoming the members of the Task Force and members of the public in attendance. Chairman Nicolay explained that the Task Force convened this Public Forum to receive and consider comments on Maryland's Certificate of Need Program, with particular focus on the three areas of the Task Force's charge: to propose modifications to the procedures, services, and facilities that are covered under the program, enhancements to the application process, and enhancements to the monitoring of Certificate of Need-approved projects under development. The Chairman noted that the members of the Task

Force represent a broad cross section of Maryland's health care community, and that the Commission is grateful for their participation.

Chairman Nicolay introduced Commission Chairman Stephen J. Salamon, who was instrumental in the creation of the Certificate of Need Task Force. Chairman Salamon welcomed everyone on behalf of the entire Commission, and thanked the Commissioners who had given their time to serve on the Task Force, as well as the other members, whom he appointed in order to bring broad geographic representation and a wide range of expertise and experience to this effort. He thanked the Commission's staff, as well as the stakeholders and other members of the public for their participation. Chairman Salamon stated that the objective of the Task Force is to examine the Certificate of Need program and the health care services under its authority, as established in Maryland law, through a "stakeholder-driven" process. He emphasized the importance to the Commission of this active participation by stakeholders in the health care system.

Chairman Nicolay then briefly described the work plan for the Task Force, which will meet during the months of June, July, and August to analyze today's public testimony and any written comments received by 4:30 p.m. on Friday, June 10, 2005. The Task Force will present recommendations to the full Commission at its September meeting. Between September and December of 2005, any recommendations requiring regulatory changes will come to the Commission as proposed regulations, which will afford an additional period of public comment. Any statutory changes needed to accomplish changes to the Certificate of Need program recommended by the Task Force and adopted by the Commission could be proposed to the 2006 session of the General Assembly.

Chairman Nicolay explained that the Public Forum was scheduled for three hours, until 1:00 p.m., and that he would use the full time allotted, and allow more time, if needed, in order to be able to hear from any person or organization present that wanted to address the Task Force. Consequently, he would place no time limits on testimony, and expected that Task Force members would ask questions for clarification or further information during each person's testimony.

## 2. Public Forum Comments

### 1. Lawrence Merlis, President and CEO of Greater Baltimore Medical Center

Mr. Merlis presented the recommendations of the Greater Baltimore Medical Center ("GBMC") on the scope of services and facilities regulated under Certificate of Need, which proceed from the belief that sophisticated and large medical centers should be able to provide a full array of services to their patients and the communities that they serve. GBMC believes that, as currently structured, Maryland's Certificate of Need program prevents it from accomplishing that objective. Despite "tremendous advances in clinical care and clinical technology" over the past twenty years, Mr. Merlis, said, the

scope of medical services covered by CON regulation has remained basically unchanged. GBMC recognizes the important role of Certificate of Need in the review and analysis of large capital construction projects proposed by hospitals -- issues related to increases in hospital costs and charges, and their effect on the Medicare waiver – as well as by other inpatient health care facilities.

However, Mr. Merlis argued, for clinical services, the Certificate of Need program has failed to recognize the significant changes in clinical practice and technology over the past twenty years, thereby creating an unequal dichotomy in which certain clinical services remain very tightly regulated, while equally sophisticated and, in some cases, more complex clinical services may be developed without Certificate of Need, with positive clinical outcomes and effective cost control. As examples, Mr. Merlis cited GBMC's interventional radiology program, which has treated over 2,000 patients with an "invasive, diagnostic, and therapeutic catheter-based" method; its vascular surgery program, in which surgeons insert aortic stents and grafts as well as carotid stents into many patients; and related neurosurgical and spine centers: in these services, physicians employ complex technologies in the kidney, the liver, and other major organs, but they are prevented from performing the same kinds of procedures on the heart by Certificate of Need regulation.

To address this inconsistency of regulatory authority, GBMC believes that the Commission should comprehensively evaluate the entire range of highly technological and complex clinical services – now standard practice at sophisticated community hospitals – to establish a consistent regulatory framework that achieves what is best for the residents of Maryland. Mr. Merlis stated GBMC's belief that not market dominance, not politics, and not the retention of a franchise granted by Certificate of Need should determine where quality services may be provided, and that a commitment to clinical excellence and ongoing compliance should become the focus of health care regulation.

Mr. Merlis stated that across the country, CON is being challenged in light of these medical changes and advances, and is being re-examined, he believes, because of the demands of the patients and the population for greater choice and access. GBMC believes that, for these specialized clinical procedures, a better regulatory process would be licensure, with standards developed by professional organizations, which would provide appropriate regulatory oversight, and a standard of entry and ongoing monitoring of care and quality. Licensure, he stated, would provide and create a proven method to lower costs with market competition, and would improve access and choice.

Mr. Merlis observed that, across the country, states are making changes in their Certificate of Need regulation of health care facilities: 13 states have repealed Certificate of Need, another 14 states are changing the applicability of Certificate of Need, and others, such as Illinois and Michigan, are examining the future role of Certificate of Need in regulating their health care systems. This re-evaluation of Certificate of Need as anti-competitive is consistent, he said, with the 2004 report by the Department of Justice and the Federal Trade Commission, entitled *Improving Health Care: A Dose of Competition*, which concluded that, while "CON programs are intended to control health care costs,

there is considerable evidence that they can actually drive up prices by fostering anti-competitive barriers to entry." Consistent with this view, GBMC believes that Certificate of Need programs favor market incumbents, increase costs, as well as impose a barrier to entry that hinders a thriving marketplace. Mr. Merlis provided a copy of the Executive Summary of the FTC/DOJ report for the staff to provide to the members of the Task Force.

In conclusion, Mr. Merlis said that the focus of regulatory policy should always be to provide for the benefit and needs of our patients and our communities. GBMC believes that the Commission and this Task Force need to consider options that create appropriate competition but, at the same time, address the concerns of quality and access and costs. He hoped that there will be a meaningful discussion through this process to evaluate regulation and evaluate the effectiveness of Certificate of Need, consider the elimination of Certificate of Need, as appropriate, and to implement other types of regulation, such as licensure.

**2. Andrea Hyatt and Deron Johnson, Maryland Ambulatory Surgical Association**

Mr. Johnson noted that the Maryland Ambulatory Surgical Association ("MASA"), which represents single and multi-specialty surgical centers across the state, supports the CON process as it is today for ambulatory surgery, and does not support any changes to it. Mr. Johnson also stated the position of MASA in favor of tighter definitions of what constitutes an operating room and a procedure room, in terms of their appropriate use, and the types of equipment and physical environment in each type of room. The current State Health plan for ambulatory surgical services contains a definition of several kinds of operating rooms, but not of procedure rooms. Mr. Johnson said that MASA does not have, at this point, any comments on the Certificate of Need review process or project monitoring, but will be following the Task Force deliberations and will comment as appropriate. For now, MASA believes that CON is "working fine."

Andrea Hyatt, administrator of the Dulaney Eye Center in Towson, Maryland, said that she supports Mr. Johnson's comments. She explained that there is considerable uncertainty among providers of freestanding ambulatory surgical services about the physical environment and scope of services permissible in operating rooms versus those in procedure rooms, and that the various levels of approval, licensure, and certification – between the Commission, the Office of Health Care Quality, and the Centers for Medicare and Medicaid services ("CMS") – contribute to this uncertainty. She noted that there are clear definitions available from the Guidelines for Health Care Facilities publication by the American Institute for Architects ("AIA") as well as from the various accreditation bodies for ambulatory surgery centers. Task Force member Dr. Albert L. Blumberg asked Ms. Hyatt what the disadvantage to her members would be if CON went away for ambulatory surgery. Ms. Hyatt replied that if CON went away totally, it would have an undesired effect not on just ambulatory surgery centers, but on all facilities that offer surgical procedures, citing a current crisis caused by a shortage of anesthesia providers. Ms. Hyatt noted the difficulty in obtaining sufficient staff to safely cover

operating rooms in every setting, whether in a hospital or an ambulatory surgery center. Without some limitation on entry into this market, these existing shortages would become more critical, and ambulatory surgical providers more stressed than currently is the case.

### 3. Cal Pierson, Maryland Hospital Association

Mr. Pierson, President of the Association of Maryland Hospitals and Health Systems (MHA), noted that his organization initiated its own study of the Certificate of Need program earlier this year, and has provided copies of the resulting report to the members of the Task Force. On behalf of MHA's 69 acute and specialty care member institutions, Mr. Pierson stated that Maryland hospitals have consistently supported an effective and rational CON process. Periodic comprehensive reviews such as this one have been very important to improve the process over time. MHA endorses the Certificate of Need program, he said, but believes strongly that changes can be incorporated which would streamline it and further facilitate and enhance the process. The creation of this Task Force represents a timely opportunity to "learn from our past experiences and to consider new ideas and approaches for the future."

In January 2005, MHA convened its Certificate of Need Work Group, comprised of hospital representatives and subject matter experts, to review the CON process as well as the State Health Plan, in order to identify areas of improvement. They also talked with their members, to learn about their individual experiences with the CON process.

MHA's first recommendation is to update the State Health Plan (SHP) and keep it current. MHA believes that many of the current system standards are obsolete or redundant, and should be repealed, and replaced by others more current and regularly revisited, such as the American Institute of Architects (AIA) guidelines for square footage in hospital construction.

MHA also recommends that the Commission eliminate the use of standards that are not formally adopted as regulation, in the State Health Plan. Only standards promulgated and detailed in the SHP should be used in the CON review process. Mr. Pierson stated MHA's view that the health planning and CON process has strayed from this "accepted" process of applying in Certificate of Need review only those standards formally adopted in the Plan. As a result, he said, hospitals are subject to standards that are not in the Plan, that are not available to them in advance, and cannot plan their projects and prepare their Certificate of Need applications appropriately.

MHA also recommends that the Commission align acute care bed need projections with the licensure law, making the State Health Plan's bed need methodology identical to the 71.5 percent occupancy rate, instead of its current 80 percent occupancy rate, to reflect the statutory standard for licensed beds of 140 percent of the previous year's average daily census.

The fourth major recommendation by MHA is that the definition of physical capacity in hospitals, applied by staff in Certificate of Need review, needs to take into

account modern architectural and patient care standards and public policy concerns such as the need for adequate surge capacity in the event of some kind of disaster. When a hospital submits a Certificate of Need application for renovation of existing patient care areas, along with the construction of new beds, Mr. Pierson said, there is often confusion and debate about what constitutes legitimate bed space, and a definition is needed that focuses on physical capacity and not just licensed capacity.

Mr. Pierson also summarized MHA's recommendations on the Certificate of Need review process, beginning with the review for completeness of an application. First, MHA wants to restore the original spirit of the completeness review, which, Mr. Pierson said, should only address whether necessary application components are technically complete, and not evaluate the applicant's response to those components of the application.

Second, MHA encourages the Commission to be judicious and time-sensitive in asking relevant additional questions. Mr. Pierson emphasized that MHA did not oppose additional questions following completeness review, but instead asked that such questions be relevant, and posed within 45 days of docketing, as opposed to the current practice, in which additional information questions are asked throughout the process, with little consideration of the relative importance or priority of those questions, or the regulatory timeframe involved.

Third, MHA urges the Commission to streamline standards of review and documentation, by adopting a checklist approach for documenting compliance with standards, in order to focus limited MHCC staff resources on areas where the more complex compliance problems might exist. This change would greatly reduce the time and burden required for CON applications for both applicants and the Commission staff, by making more reasonable and proportionate the amount of analysis necessary to document and demonstrate compliance with a given CON standard.

MHA's fourth major recommendation is that the Commission encourage the efficient use of resources by allowing major capital construction projects to include shell space, under certain circumstances and within certain parameters to support the efficient use of health care dollars. This would give hospitals a more cost effective alternative to starting a needed future expansion from scratch.

Fifth, MHA recommends the creation of a "fast track" review process for certain types of projects, such as those that do not include new beds and/or services. MHA envisions that, in these fast track projects, staff reports should be issued within sixty days, and a Commission decision rendered in ninety days, and if this does not occur, a project would automatically be deemed approved.

MHA's sixth recommendation is the elimination of unnecessary redocketing of applications, if changes to a Certificate of Need application are made in response to requests made by Commission staff or reviewers, changes made to the SHP, or changes to the MHCC's bed need projections.

Mr. Pierson presented two additional recommendations in one final area related to coverage of the CON process. First, MHA proposes that the statutory Certificate of Need review threshold for capital projects be raised to at least $7.5 million, with a provision for annual inflation adjustments, to better reflect the increasing costs of capital improvement projects, as well as the increasing need for physical plant upgrades. MHA believes that raising the capital review threshold to this level would relieve the Commission and its staff of the administrative burden of reviewing minor projects, and allow hospitals and other providers to begin them more quickly.

Finally, MHA recommends that the Commission expand the CON business office equipment exemption to include health information technology, since these clinically-related enhancements to a hospital's information technology improve the efficiency, effectiveness, and quality of care at a hospital, but do not necessarily relate specifically to the development of a new service. MHA recommends that clinically-related information systems and equipment be considered business or office equipment, and legally excluded from the CON process.

In concluding, Mr. Pierson said that MHA commends the MHCC for undertaking this effort to modernize the CON process, and hopes that its recommendations and full report will facilitate and improve that process, which the organization believes will result in a more efficient and effective process.

Chairman Nicolay assured Mr. Pierson that the Task Force will consider everything recommended by MHA. Commissioner Larry Ginsburg asked Mr. Pierson about the Certificate of Need Work Group participants. Mr. Pierson explained that the effort was an internal MHA review with all of its members represented as well as some outside subject-matter experts who have dealt with CON over the years, coordinated by Frank Monius, Associate Vice President of MHA. Mr. Monius noted that the ten-person Work Group also include several health care attorneys with extensive experience in the Certificate of Need program.

### 4. Mara Benner, Maryland National Capital Homecare Association

Ms. Benner, President of the Maryland National Capital Homecare Association ("MNCHA"), noted that the Association represents more than seventy home care providers and affiliates throughout the state of Maryland and the District of Columbia. She stated that – while her Association's members are equally divided on whether to support or oppose a CON program within the state of Maryland – its members concur in supporting the consistent enforcement of the current CON program, with a strong (Medicare) survey process. MNCHA also wants any additional regulations affecting Medicare-certified home health agency providers to be both fair and equitable.

MNCHA believes that another key aspect is to assure that any new CON regulations are fair and reasonable. Ms. Benner noted that new regulations enacted in October 2003 impacted CON providers who had been grandfathered into the system,

prohibiting newly-acquired home health agencies from serving any jurisdiction in which its predecessor had not provided services during fiscal year 2001, even if the predecessor agency had held a documented authority to serve that jurisdiction. Ms. Benner said that these types of regulatory modifications slowly erode the integrity of the originally authorized CON.

On the issue of enforcement, MNCHA members report that agencies are entering counties where they currently do not have Commission authority to provide services. Ms. Benner stated that it was critically important to enforce the regulatory authority of all home health agencies, whether the agencies obtained that authority through grandfathering, through Certificate of Need approval, or by acquisition of an existing agency.

Finally, Ms. Benner said that MNCHA members strongly believe that agencies should be surveyed on a consistent basis to verify compliance with the CON. This will contribute to "assuring stability of providers within the market," and help patients, physicians, payors, and state officials to know the agencies and know their services. She emphasized the importance of regular licensure and certification surveys in assuring the quality and safety of health care provided in a patient's home. Ms. Benner stated that the MNCHA membership looks forward to working with the Task Force and providing any additional information that is needed.

Commissioner Robert Moffit asked Ms. Benner if her concern for better and more consistent enforcement of Certificate of Need authority implied that the Commission was doing an inadequate job of that at present. Ms. Benner replied that this was MNCHA's main concern. Commissioner Moffit said that this would mean that the Commission or state agencies would have to increase their presence, which would likely cost providers more in licensure and other fees. He asked if MNCHA would favor an increase in the fees to cover increased compliance. Ms. Benner replied that the main concern of the membership is that if there is a CON, it needs to have integrity and be enforced; if Certificate of Need coverage for home health agencies is repealed, she said, those issues go away.

### 5. Robert Johnson, Jewish Social Service Agency

Mr. Johnson, CFO of the Jewish Social Service Agency ("JSSA"), said that his agency would like to retain CON regulation of hospice services. JSSA serves approximately 12,000 clients in Maryland, in Montgomery County. Its hospice has been in existence since 1984, providing hospice care on a fully non-sectarian basis. JSSA's hospice has become symbolic of the Jewish community and its commitment to care. Non-profit agencies such as JSSA operate on a relatively small, but comprehensive, basis, and work very hard to support families who are facing terminal illness and want to care for their loved ones at home. JSSA believes that if Certificate of Need coverage of hospice services is not maintained, the state will be placing community hospices like that of JSSA -- with long histories of high quality care, and a prompt response with charitable support for poor clients -- in jeopardy. JSSA must do extensive fundraising to raise

money to support care for Medicare- and Medicaid eligible patients, and to provide care to patients that cannot afford to pay. Nonprofit, community-based hospices such as JSSA provide exceptional quality of care. They are rooted in the community, they mobilize volunteers and fundraising dollars, and they are held accountable to their community boards for their quality of care and commitment. At the same time, they are JCAHO-accredited.

Mr. Johnson said that local nonprofit hospices like JSSA cannot commit extraordinary money for marketing campaigns, although they are well-known by all of the local hospitals and referral sources; they must reserve dollars for patient and family care. Local nonprofit hospices are already struggling under shortages of nursing; removal of the Certificate of Need coverage, with the resulting ability for an unlimited number of new providers into this market, would add to that in competition for charitable dollars. Mr. Johnson stated that allowing outside hospices to come into this area would jeopardize the very existence of community-based hospices which have superb reputations. He noted that JSSA has nurses who are available twenty-four hours a day, seven days a week, 365 days a year to give care. JSSA believes that a compelling need for competition in hospice care would only exist if the quality of care is lacking, and JSSA does not believe this problem exists in Montgomery County.

### 6. Erwin Abrams, Hospice Network of Maryland

Mr. Abrams began by noting that he was speaking both as President of the Hospice Network of Maryland, and also for his agency, Hospice of the Chesapeake. He asked that all representatives present at the Forum representing community-based hospices around the state raise their hands in support of the Certificate of Need process, and said that their presence shows the importance of continuing Certificate of Need coverage to current hospice care providers. Mr. Abrams noted that hospice care has been subject to regulation under the Certificate of Need program for nearly twenty years, and that, under this regulatory structure, hospice care in this state has developed into a thriving, vibrant community. While numerous efforts to deregulate hospice have arisen over the past several years, Mr. Abrams stated that no evidence has been offered to suggest that a change in this regulatory structure would provide any benefits to the terminally ill of the state of Maryland.

Because volunteers are essential elements in home based care, many agencies compete for their time and commitment. Continued regulation of new hospice providers through CON will ensure that the supply of qualified volunteers can meet the demand of the number of certified hospice providers. Mr. Abrams pointed out that the majority of the thirty hospice providers in Maryland are not-for-profit agencies, and therefore rely greatly on the generosity of local donors for fundraising dollars. Increased competition for community donations would increase the considerable pressures of securing economic support for hospice services. According to the Hospice Network's surveys of care provided in 2000, 2001, and 2003, existing hospice care providers are meeting the end of life needs of the citizens of Maryland and is growing as the need grows. Mr. Abrams and his organization believe that retaining the authority to consider additional hospice care

providers only when additional need warrants will help maintain the stability of the mission-driven, mostly not-for-profit community that is heavily dependent on volunteers, and the experience of professional staffs.

Mr. Abrams pointed out that in a study of hospice care, the Commission presented ample evidence that CON has produced high quality end of life care for the citizens of this state. He concluded that the economies of scale available when the number of hospice programs is limited to those needed, the special circumstances that pertain to rural areas with a delicate balance of resources and demand, the need for continuing local control and operation of these community-based agencies, the necessity for hospices to devote every dollar possible to patient care, and the need to retain scarce staff and still compete in the market place all lead the Hospice Network of Maryland to implore the Task Force to retain Certificate of Need for hospice as it is.

Task Force member William L. Chester, M.D. asked Mr. Abrams if he believes that the Certificate of Need process for hospice adequately addresses the issues of end of life pain management. Mr. Abrams replied that the Certificate of Need process addresses this issue, through the requirements of hospice programs described in the applicable State Health Plan review standards, but that the professional community of physicians and palliative care nurses around the state are also addressing this issue, thanks to the Maryland End of Life Project, and its partnerships with hospitals around the state. Task Force member Barry Rosen asked Mr. Abrams how many hospices his organization represents. Mr. Abrams replied that the Hospice Network represents all thirty hospices in the state of Maryland.

Commissioner Moffit asked Mr. Abrams to confirm that he thinks that the current CON program is fine and that their recommendation was for no change in Certificate of Need. Mr. Abrams replied that was correct. Commissioner Moffit asked if there was anything that Mr. Abrams could think of that would improve the Certificate of Need for hospice care. Mr. Abrams said that the Hospice Network of Maryland members are always interested in working with the staff and the Commission to ensure that regulations are strengthened, and that the monitoring of quality of care, whether through Certificate of Need review or by the State's licensure programs, is always desirable.

### 7. Sue Ellen Stuart, Gentiva Health Services

Ms. Stuart, Maryland Area Director of Gentiva Health Services, noted that Gentiva is the nation's largest, comprehensive provider of home care services. Gentiva serves clients in Maryland through its offices in Pasadena, Maryland. Ms. Stuart stated that Gentiva is supportive of the current CON process if, and only if, the CON is enforced, agencies are consistently surveyed, and all regulations are fair and equitable in their implementation. As a home health agency on a national scale, Gentiva currently provides services in both states with and without CON. One of its main concerns has been the influx of providers in other states without CON. Ms. Stuart cited the example of Florida, which eliminated the Certificate of Need requirement for home health agency services on July 1, 2000. Under the CON requirement, approximately twenty new

providers sought Certificate of Need approval annually. Since the elimination of CON, that number has increased five times, to 120 per year. In real numbers, the State of Florida had 330 Medicare-certified home health agencies in May 2002; three years later, in May 2005, the state now has 658 Medicare-certified home health agencies. Similarly significant increases in the number of certified home health agencies occurred in other states that repealed the Certificate of Need requirement, and Ms. Stuart offered to share Gentiva's information on this issue with the Task Force.

Ms. Stuart said that the increase in providers makes it very difficult to appropriately assure the quality of the services being delivered to the patients needing care, and strains resources available to ensure that the provider is a legitimate provider. Gentiva believes it is critically important to ensure that the CON has integrity, and that providers are caring for patients in their designated CON area. Gentiva also believes that ongoing and consistent survey reviews support the integrity of the regulatory authority conferred through Certificate of Need. Ms. Stuart said that CON should ensure that providers are being surveyed and reviewed in a timely manner and that they meet the CON requirements.

On behalf of Gentiva, Ms. Stuart stated its belief that the Commission has implemented regulatory changes that were not reasonable, citing the October 2003 adoption of a regulation providing that the purchaser of an existing home health agency may only acquire the authority to offer home health agency services in jurisdictions in which the Commission's records show that the facility being acquired either provided that service in fiscal year 2001, or was granted a Certificate of Need after that date, based on the agency's annual reports. While this regulation does not seem to have an immediate impact on a home health agency, it does immediately imply that "their CON is no longer reflective of all of their originally designated counties."

Gentiva strongly urged the Commission to assure a fair and reasonable approach, in making any regulatory changes affecting the Certificate of Need program, and its coverage of home health agencies. The most important factor to Gentiva is assuring quality and stability of home care services to the patients, and for the providers. If the Commission ultimately chooses to eliminate the CON, Gentiva strongly urges Maryland to adopt a fair but strong home care licensure program. This licensure program should assure that those entering into the market meet certain standards and that quality of care is maintained, even after they begin their new home care business.

Ms. Stuart noted that Gentiva is currently represented on the Maryland Department of Health and Mental Hygiene In-Home Health Care Forum, which is reviewing the entire statutory and regulatory framework governing entities that provide some level of health care in people's homes. If DHMH decides to seek changes to the current structure of licensure for home care providers, Gentiva hopes that the Department will seek strong quality control and appropriate oversight for patients, and for providers. Ms. Stuart concluded by stating Gentiva's commitment to work with the Task Force as it considers potential changes to the Certificate of Need process and coverage of health care services.

Lynn Bonde, Task Force member, asked if home health agencies are subject to Office of Health Care Quality (OHCQ) licensure regulation and surveys. Ms. Stuart replied that they are. Ms. Bonde asked if she understood correctly that Gentiva feels these regulations and surveys should be strengthened. Ms. Stuart answered that what appears to be happening is that currently surveys happen only when there is a complaint, rather than on a routine basis.

Dr. Albert Blumberg, Task Force member, asked about Ms. Stuart's relation of the Florida experience, in which the number of Medicare-certified home health agencies doubled in the two years following elimination of the Certificate of Need requirement. He asked if he was correct in assuming that Florida did not impose a strong licensure program, at the same time it eliminated the Certificate of Need requirement. Ms. Stuart did not know whether Florida strengthened its licensure and other market-entry requirements at the same time it deregulated home health agency programs from Certificate of Need.

Chairman Nicolay requested that Gentiva provide the Task Force with the data on other states' experience following deregulation from Certificate of Need that Ms. Stuart mentioned during her testimony. Ms. Stuart said that she would send the additional data to the Commission's staff.

### 8. Danna Kauffman, Mid-Atlantic LifeSpan

Ms. Kauffman, as Director of Public Policy for Mid-Atlantic LifeSpan, a senior care provider association representing a continuum of settings of care, began by endorsing the recommendation of the Maryland Hospital Association for an expedited review and application process. She said that the state needs to understand that one size does not fit all, and that there are circumstances where an expedited review would benefit both the Commission as well as Maryland in general. Many Maryland nursing homes need renovations, whose cost adds up very quickly. Mid-Atlantic LifeSpan believes that, in the case of renovation process with little or no impact on other providers or the surrounding community, it would be advantageous for the Commission, as well as the state and the providers, to have an expedited review process. Her organization urges the Commission to develop an expedited application process, in consultation with nursing home providers, and said that Mid-Atlantic LifeSpan would provide further comments on this issue in written form.

Task Force member Douglas Wilson, Ph.D. asked if Mid-Atlantic LifeSpan advocates an increase in the Certificate of Need review threshold for capital projects; Ms. Kauffman replied that her organization supports MHA's recommendation to raise the capital threshold.

### 9. Elizabeth Weglein, Maryland National Capital Home Care Association

Ms. Weglein, Government Affairs Chair for the Maryland National Capital Home Care Association ("MNCHA") noted that the Association represents five sectors of the home care industry, including the Medicare-certified home health agencies currently subject to Certificate of Need review and approval in Maryland. Ms. Weglein also noted that MNCHA represents the residential service agency (RSA) sector, which includes private duty nursing and other home health services, providers of durable medical equipment, as well as nurse referral agencies, hospices, and nurse staffing agencies. The Association is currently considering its position on the question of Certificate of Need regulation of Medicare-certified home health agencies in Maryland. It is now officially neutral on this issue, but believes that it should investigate further what the effects would be on the whole range of home care providers if the Certificate of Need requirement on one sector were to be repealed. The Association intends to share the results of this analysis as its efforts move forward, and asked to be involved in the work of the Task Force, since its recommendations will be critically important to the industry it represents.

### 10. Howard Sollins, Esq., representing the Health Facilities Association of Maryland

Mr. Sollins, of the law firm Ober, Kaler, Grimes & Shriver, noted that he serves on the Planning and Regulatory Committee for the Health Facilities Association of Maryland ("HFAM"), and was providing testimony on HFAM's behalf, as the representative of more than 150 of Maryland's 260 nursing home providers.

HFAM supports maintaining Certificate of Need coverage of comprehensive care facilities ("CCFs"), the licensure category of Maryland nursing homes. Mr. Sollins noted that in neighboring Pennsylvania, whose Certificate of Need program ended in 1997, the Medicaid program instituted a replacement program that continues to review proposals for new nursing home beds and facilities, because of the relationship between the supply of nursing home beds and the predominant source of reimbursement for those services, the Medical Assistance program.

Mr. Sollins stated that the nursing home industry favors a flexible approach to capital improvements that benefit residents: because of the overall age of much of the industry's physical plant, many facilities need significant upgrades, and these projects very quickly reach the current capital review threshold of $1.65 million. Some facilities need total replacement, and often must identify a site elsewhere in the same community. Each of these actions is now regulated through the CON process. The nursing home industry needs more flexibility to undertake these capital projects, and seeks parity with the hospital industry, in its recommendation to increase the capital review threshold. HFAM also endorses MHA's suggestions to exclude from Certificate of Need review any expenditure for electronic health records or other information technology that improves quality or efficiency of care. The Association similarly concurs with MHA's recommendation that the Commission permit a certain amount of shell space to be included within a Certificate of Need-approved capital project. In nursing homes, the

availability of unprogrammed space can be important in a natural disaster, as happened during last summer's series of hurricanes in Florida, and can also serve as an impetus for the development of community-based services, as an alternative to nursing home admission. Considerable discussion is currently ongoing about the important role of community-based long term care services, and HFAM is an important stakeholder in these discussions, since nursing homes are often a springboard for the development of dialysis, adult day care, assisted living, and other community-based settings of care.

Mr. Sollins noted that HFAM agrees with previous testimony that, in uncontested cases in which no new service is involved, the Commission should establish an expedited review process. He also urged the Task Force to consider extending the ability to undertake a capital project in identified phases within its overall performance requirements – now available only to hospital projects that meet the regulatory definition of "multi-phased construction projects" and over a specified amount of capital cost – to smaller, less costly projects.

HFAM also agrees that the State Health Plan needs to be updated regularly, and kept current. Several issues related to current State Health Plan standards should be addressed in the next update of the Plan. First, the Plan currently subjects applications to expand existing facilities, including those involving capital expenditure over the review threshold – as well as to establish new bed capacity or a new facility – to a standard requiring that every other existing nursing facility in the jurisdiction be at or above 95% occupancy. The Plan permits an applicant to explain reasons why given facilities are below that occupancy level, but HFAM urges that the Commission re-examine the policy itself, since relatively few facilities across the State or the nation are operating at that level. To subject any capital improvement project that expands bed capacity to such a high benchmark operates as an effective barrier, in some cases, to an otherwise beneficial capital project.

Another State Health Plan issue of concern to HFAM is an apparent change of Commission policy with respect to the re-implementation of existing nursing home bed capacity, at another site or another existing facility. This issue was a key element in a recent Commission staff report on a proposal seeking Certificate of Need approval to relocate beds from a hospital-based extended care facility at an existing nursing home in Western Maryland. Subjecting beds already in the system to a showing of continuing need seems to the industry to be a change in policy that should be discussed thoroughly. HFAM agrees with previous comments that the entire issue of licensed versus physical bed capacity needs further discussion, so that the industry knows the Commission's thinking, as it seeks ways to maintain services and use existing physical plants more efficiently.

A third State Health Plan issue that HFAM believes needs re-examination is the requirement that, in order to receive Certificate of Need approval, nursing homes seeking to establish or expand bed capacity or to undertake a capital expenditure over the review threshold must execute a Memorandum of Understanding ("MOU") with the Medicaid program. This MOU is a commitment on the facility's part that it will maintain an annual

average number of Medicaid patient days at least equal to either the jurisdictional or the regional average, whichever is less.

This Plan requirement dates from a time when Medicaid recipients, or those about to spend down to Medicaid, did not have ready access to nursing home care; HFAM believes that this standard is no longer necessary. The MOUs developed in response to this review standard are being actively enforced by the Medical Assistance program, and this is problematic for two reasons: first, being below the agreed-upon level may result in a penalty to providers, in lower Medicaid reimbursement rates, and, second, it may provide a disincentive to encourage Medicaid recipients to seek community-based settings of care, since to do so would reduce a facility's Medicaid occupancy. HFAM believes that the problem of access to care for Medicaid recipients no longer exists, and that the MOU requirement is therefore outdated.

Mr. Sollins noted that the Commissioners have recently discussed, in the context of a matter before them, the statutory requirement that Commission-regulated health care facilities – other than hospitals – must obtain a Certificate of Need to close. In addition, any proposal to re-implement the beds at another location in the jurisdiction, whether at a new or an existing nursing facility also requires Certificate of Need approval. HFAM suggests that this process can be made much more efficient, such as by the assembling of a comprehensive project to come before the Commission for a single Certificate of Need review and approval. The State Health Plan could provide for this approach. HFAM believes that the Commission should also consider the broader question of whether its statute should continue to require a Certificate of Need for the closure of any category of health care facility. This should become a notice requirement only.

Mr. Sollins urged the Commission to re-consider what he described as its new use of a comprehensive published schedule for Certificate of Need reviews for all kinds of nursing home projects, not simply those involving new beds, or a new facility. Within that published review schedule, he said, the Commission has also changed the historic practice of allowing 180 days in which to submit a Certificate of Need application following the filing of a Letter of Intent to apply, instead requiring that an application be filed within 60 days of the Letter of Intent submission, in a scheduled review. The effect of this schedule is that many applications may now arrive simultaneously; this further strains staff resources, and adds to the time it takes to obtain a decision. Although the industry works well with Commission staff, which is collaborative in working with applicants in meeting these deadlines, the Task Force process presents an opportunity to re-evaluate about how the Certificate of Need process works, especially in the context of a set schedule for Certificate of Need reviews.

On behalf of HFAM, Mr. Sollins also observed that – although the Certificate of Need process is characterized by time deadlines – there is no deadline within which the agency needs to get back to the applicant with the results of its review of responses to completeness questions. HFAM also endorses the comments made earlier about the distinction between docketing questions, completeness questions, and additional information questions. Over time, those questions have tended to be blended together,

and HFAM agrees with MHA and other commenters that these distinctions should be revived.

Finally, Mr. Sollins observed that the historic orientation toward evidentiary hearing, inherited from the defunct federal Certificate of Need review process, was changed in 1995, when the former Health Resources Planning Commission proposed and the legislature enacted a measure to streamline the review process. In place of the evidentiary hearing, the statute permitted applicants and interested parties in contested cases to request an opportunity to oral argument before the Commissioner acting as reviewer in the matter. In practice during the ten years since this provision was enacted, Mr. Sollins noted, oral argument is rarely held. Thus, an applicant can be in a contested review, and never have the opportunity for an exchange with the Commissioner who is the Reviewer on your case.

HFAM believes that the Certificate of Need process is an important part of the state's process for considering the future and current health care needs of Marylanders, and favors a health planning process that reflects current data, fosters the ability of providers to compete effectively through new and better programs and services, eliminates barriers to providers seeking to improve the fiscal environment in which quality care is rendered, and enables providers to use the economic value of their beds as part of that process. HFAM therefore urges the Commission, as the Task Force is upgrading and updating the Certificate of Need process, to think about small providers who have property rights, who have need and ability to use that capital to fund community-based services, and not to move toward a CON process that jeopardizes that value. HFAM believes that the Commission can continue to maintain a CON process that provides important benefits to the people who are served by long term care providers, with the right balance between inpatient services and community based services.

Task Force member Carlessia A. Hussein, Dr.PH, asked Mr. Sollins if he is aware of data documenting that Medicaid patients have adequate access to nursing home services, and whether HFAM could provide that data. Mr. Sollins replied that he works with many providers who serve Medicaid patients, and felt that providers seek Medicaid patients in times of declining occupancy, noting that the District of Columbia is currently working to assure that its Medicaid recipients are admitted to DC nursing homes, rather than to Maryland nursing homes.

Task Force member Jack Tranter asked what specific changes HFAM recommends to the current practices of completeness review. Mr. Sollins replied that the initial ten working days allotted in Certificate of Need procedural regulations for completeness review are sufficient, and that there should be a ten to fourteen day timeframe for completeness instead of the present thirty days, which includes the time period necessary to submit a docketing notice for publication in the *Maryland Register*, which initiates the statutory thirty-day public comment period.

Task Force member Barry Rosen asked whether the rationale for requiring Certificate of Need approval for nursing homes is still related to concerns about stress on the Medical Assistance budget, and other forms of reimbursement. Mr. Sollins replied that under Medicaid, private pay dollars are shrinking, Medicare payment is prospective, and that Medicaid payment is based on five cost centers. Medicaid has substantial control that it makes sense to maintain.

Task Force member Joel Suldan asked if the per-bed cost of construction or renovation in current nursing home projects exceeds the allowable portion of capital costs set by Medicaid program, when it assigns a facility's Medicaid rates. Mr. Sollins replied that whether a facility's capital and interest costs exceed the Medicaid formula's cap depends on several factors, including the age of the physical plant. For those facilities whose capital costs exceed the cap, there is intense economic pressure.

Task Force member Hal Cohen asked if Mr. Sollins's discussion of the economic value of nursing home beds referred just to Medicaid reimbursement issues, or to the larger question of any value the beds could hold as a financial asset to a provider, because the overall supply of nursing home beds is controlled by the State health Plan's need projections. Mr. Sollins responded that he was addressing the general concerns. In recent years, the sale of nursing home beds by smaller, older, family-owned facilities allowed for forward-looking people to buy the beds and collect them into more modern facilities. That the owners of existing beds might become subject to new need analysis, and their re-use in a new facility might need to be re-justified would negate the "value of licenses in this marketplace."

**11. Donna Jacobs, University of Maryland Medical Systems ("UMMS")**

Ms. Jacobs stated that UMMS agrees with many issues and ideas raised by previous testimony, including that of MHA, particularly with respect to making the Commission's State Health Plan need projection methodology for acute care beds assume the same level of overall occupancy as that of the statutory provisions related to the annual recalculation of licensed acute care beds, enacted in 1999. UMMS believes that the so-called "140% rule" – assigning to each hospital a number of licensed beds equivalent to 140% of its average daily census from the previous year – is a better measure of a hospital's actual average daily census and more reflective of the hospital's actual need than a jurisdictional bed need projection, generally based on a higher average occupancy target. UMMS believes that not balancing this inconsistency between the State Health Plan and the licensing statute may have a negative impact on future hospital growth and patient access to acute care services in the state.

UMMS also wished to comment on the Commission's existing regulations that establish different performance requirements, or allowable periods of time applicable to large capital expenditure projects for construction, demolition, or renovation, at COMAR 10.24.01.12. These performance requirements, for "multi-phased construction projects" at hospitals over a specified total cost, require that hospitals obligate 51% of the total capital expenditure for the first phase of construction, and that the first phase be

completed in twenty-four months. For projects over $60 million, Ms. Jacobs stated that this large up-front obligation of capital presents a significant burden, since some of these large-scale projects may take a total of five to seven years to complete. Ms. Jacobs cited the example of three large capital projects, which – had they been Certificate of Need-approved projects, instead of approved via "the pledge" – would have presented this dilemma to UMMS. The first phases of all three projects – the Shock Trauma Center, the Homer Gudelsky Building, and the Weinberg Building – took longer than 24 months, yet all three projects fell within their own construction schedules. UMMS therefore suggests that these implementation standards are too prohibitive for the larger scale projects, and asks that the Task Force reconsider the time line and the portion of capital costs that a hospital must obligate at the start of each approved phase of construction.

UMMS agrees with several previous commenters that the Certificate of Need review threshold for capital projects should be increased, and recommends that the threshold be set at $10 million. Eighteen of the twenty-one CON projects on file and under review by the Commission exceed the current threshold of $1.65 million, but only nine of those projects exceed a $10 million threshold. The state's capital expenditure threshold is below the mid-range among the states with CON across the nation; in our neighboring states, Delaware and Virginia both have a $5 million review threshold, and the District of Columbia's threshold is set at $2.5 million. The highest review threshold for Certificate of Need review of capital projects is that of Massachusetts, at $10.2 million.

On behalf of UMMS, Ms. Jacobs raised the issue of Certificate of Need coverage for inpatient obstetric services: UMMS believes that obstetrics is a basic service that should be provided by any community hospital, without the need to obtain Certificate of Need approval. Any hospital that can demonstrate that it meets quality standards established by a recognized authority – such as the Maryland Perinatal Standards adopted as regulation by the Maryland Institute for Emergency Medical Services Systems (MIEMSS") – should be able to provide the service. UMMS questions the logic behind the Commission's continuing requirement of Certificate of Need approval to establish a new hospital obstetrics service, when a hospital may open a freestanding birthing center in Maryland by obtaining a license from the Office of Health Care Quality. In practice, Ms. Jacobs said, since hospitals without a formal obstetrics services can deliver babies in their emergency rooms or in their operating rooms under certain circumstances, the service is being provided in hospitals without Certificate of Need approval, but in an environment that is far less optimal in terms of patient access and patient care and quality. Being able to add an obstetrics service, without Certificate of Need, would enable all hospitals to provide the best quality care, as well as to support related subspecialties, such as general gynecology, uro-gynecology, and general OB services.

Finally, Ms. Jacobs endorsed on behalf of UMMS the recommendation by MHA that clinical information technology acquired by acute care hospitals should not be subject to Certificate of Need review. Clinical information technology will improve patient safety in hospitals and ambulatory care settings and will enhance the efficient and effective delivery of health care services, so acquiring this capability is clearly in the

public interest. Because advances in this field are occurring so rapidly, the additional time required to obtain Certificate of Need approval can delay implementation of the most up to date and effective systems. The use in hospitals of sophisticated clinical information systems will become the standard of care, and a necessary part of providing health care to patients, managing complex health care providing organizations, supporting research, and training our future clinicians, nurses and other health care professionals

Task Force member Alan Bedrick, M.D. noted that within the state of Maryland, every pregnant woman is within thirty minutes of an acute care hospital with an existing obstetrics service; he asked Ms. Jacobs what efficiencies and or cost containment purpose would be served by permitting a hospital to establish a new obstetrics service in a geographic region in which hospitals already provide these services. Ms. Jacobs replied that UMMS understands that geographic access to obstetrics services currently exists, but that this fact has not stopped an annual average of about 170 women presenting to North Arundel Hospital to deliver their babies. UMMS believes that this situation indicates significant demographic shifts in northern Anne Arundel County, and a greater need for this basic service to be available as close to home as possible, especially when the population is growing.

Task Force member William Chester, M.D. noted that, related to this question of new obstetrics services, another important issue is adequate coverage of medical services directly affected by the presence of an obstetrics program, pediatrics and anesthesiology; the latter service is particularly stressed by the presence of obstetrics, which is time- and labor-intensive for anesthesiologists. Hospitals are forced to subsidize these related services, which – with staffing shortages – is becoming increasingly costly. Dr. Chester asked Ms. Jacobs what she thought that the impact of removing Certificate of Need coverage for obstetrics services would be on this situation. Ms. Jacobs said that she would take that question back to UMMS, and address it in the system's written comments.

Dr. Hussein noted, with regard to Ms. Jacobs' support for deregulating from Certificate of Need the capital expenditures related to the acquisition of clinical information technologies, that these systems can be extremely costly, and wondered what alternative mechanisms could help ensure that hospitals acquire and use high quality, reliable, and cost-effective systems. Ms. Jacobs suggested that, as these information systems evolve, she would expect the hospitals and other health care providers contracting for them to become more sophisticated about the technology, and also to share information about the best vendors and systems.

Task Force member Henry Meilman, M.D. asked if UMMS has considered the possible impact of transferring high-risk mothers and infants to a tertiary care center, as possibly preferable to having an on-site obstetrics program at any hospital. Ms. Jacobs responded that not to have practitioners experienced in obstetrical care on site when women in labor are presenting itself constitutes a risk for hospitals, and this risk is intensified by the presence of high-risk mothers and infants. Ms. Jacobs agreed that there

would always be cases requiring transfer to a tertiary center or to an academic medical center, but most of the cases coming to North Arundel Hospital fall just under that threshold, and most patients are appropriate for care at a community hospital.

Chairman Nicolay observed that the Task Force is concerned about and interested in this issue, and would appreciate any data and other information on this issue that UMMS or other commenters can provide.

### 12. Sam Moskowitz, Mercy Health Services

Mr. Moskowitz stated Mercy's support for the Certificate of Need process, and his intention to focus on three issues in his presentation to the Forum. Mercy first recommends that the bed need methodology of the State health Plan's acute care chapter be revised, to consider hospitals that serve multiple jurisdictions, those with service areas that extend past the borders of the city or the county in which they are actually located. While the current jurisdiction-level bed need methodology may work in single hospital jurisdictions, it does not make sense in jurisdictions with multiple hospitals, including Baltimore City, where several hospitals have broad service areas based on programs that attract patients from outside of Baltimore City. Mercy's Center for Women's Health and Medicine is one example of such a program, and Mercy has other programs, in vascular surgery and orthopedics, that bring patients into Baltimore City from other parts of the state. The current acute care bed need methodology penalizes hospitals that serve other jurisdictions, by limiting their projected bed need to only the demographic factors in the jurisdiction in which the hospitals are located. Mercy recommends that the Commission revise the way it projects acute care bed need to allow hospitals whose service area is multi-jurisdictional to benefit from population growth occurring within the hospital's entire extended service area. Mercy also believes that the Commission should consider historical growth of hospitals of this type, in projecting future bed need within each of those jurisdictions.

Mercy's second recommendation concerns the "target year" of the Plan's bed need projections, which is now 2010; Mercy believes that the target year should be extended to 2014. Mercy understands that the acute care chapter projection will soon be updated and extended to 2012, based on 2004 data projected eight years into the future. Mercy believes that the Task Force should recommend a ten-year planning horizon for acute care beds, to enable hospitals to better plan their future needs.

Mercy also recommends that the Task Force provide guidance on the circumstances in which the Commission would allow hospital capital projects to include a specified amount of unprogrammed, or "shell" space. As a related change in policy, Mercy recommends that hospitals that are land-locked be allowed to replace existing antiquated inpatient space even though that space will not be demolished, or immediately converted to another patient care-related use. At present, Commission staff focuses on a hospital's total physical capacity in assessing whether new capacity may be constructed, but in the process includes existing space that no longer meets current standards and that the hospital wishes to remove from active use as a result of a new construction project.

Mercy's third recommendation concerns other State Health Plan Certificate of Need review standards that need to be modified or eliminated, in particular the standard at Section .06B(9) in the Acute Care Chapter, which identifies the maximum amount of departmental gross square feet for new construction projects. Hospitals across the state are examining their antiquated physical plants, and need an updated standard for allowable departmental gross square feet that takes into account a patient safety perspective in the context of a move to all private rooms. Maryland is considered a national leader in health care, and the Commission should bring this important Plan standard up to date, using the American Institute of Architects guidelines and other sources.

### 13. Andrew Solberg, A.L.S. Healthcare Consultant Services

Mr. Solberg, a health care planning consultant for thirty years, began by stating his long-abiding respect for Maryland's health planning efforts, and a desire that it be effective and well respected. He worked for the Commission's predecessor agencies for approximately ten years, first as a planning and CON analyst, then as the Chief of Plan Development, and finally as the Director of the CON program. He also taught a course in comprehensive health planning at the Johns Hopkins School of Public Health for nine years.

For the last twenty years Mr. Solberg has operated his own health planning consulting practice, assisting clients in strategic planning, market studies, development of outreach programs, applications for Certificate of Need, and other related matters. While he participated in the Certificate of Need Work Group on which MHA's comments were based, he emphasized that the comments he presented were his own, and not made on behalf of any client. His written comments, he said, would include recommendations related to the review process itself, including simplifying the format of decisions; returning to the original purpose of completeness review; modifying the Commission's perspective on bed need; adopting all standards used in Certificate of Need review into the State Health Plan; allowing facilities to have "shell space" when it makes sense; fast tracking certain kinds of CON reviews; excluding information technology projects from Certificate of Need review; eliminating CON for home care and hospice; eliminating CON for closure of facilities; changing the scheduled review process; and changing the regulations applicable to the modification of CON applications under review.

Mr. Solberg said that his most important recommendation was that the Commission update the State Health Plan, many of whose individual chapters are quite old, and need to be revisited. The Commission has not undertaken a comprehensive, integrated revision in many years, and, as a consequence, does not appear to have a comprehensive vision of where the health system should be headed. The Commission should take a fresh approach to developing new standards. Every standard should address a documented problem in health care delivery, and demonstrate that it will be effective in resolving the problem, or improving the system.

Mr. Solberg urged the Task Force to recommend that the Commission undertake a complete overhaul of the State Health Plan, which needs to express what the Commission wants to achieve through the CON process. The Certificate of Need process is only an implementation tool for exercising the Commission's vision that it articulates and publishes as regulation, in the State Health Plan. The Plan can have great authority, and it should drive the Certificate of Need process. Through the publishing of its policies and standards as regulations, the Commission tells the regulated industry what it wants to see developed in the health care system. The kind of give and take that occurs during the Plan development process, and the clarity of policy that results, leads to mutual respect between the industry and the regulators. It would benefit the Commission to have more visibility in an active planning process.

Task Force member Terri Twilley, MS, RN, asked why Mr. Solberg proposes elimination of CON for the home care and hospice. Mr. Solberg responded that when he was the director of the CON program in 1982, he testified before the legislature that these community-based, non-facility health care services should be deregulated. Accurately determining the need for new capacity in these areas is difficult, because an agency can expand its patient census simply by adding staff. Members of the legislature may have strong views on maintaining the Certificate of Need regulation of home health agencies and hospice programs, but it is important to recognize that these are not reasons directly related to effective good health planning and regulatory practice.

### 14. Sean Flanagan, St. Joseph Medical Center

Mr. Flanagan said that most of his hospital counterparts, as well as Mr. Pierson of MHA, had addressed many of the issues that St. Joseph Medical Center wanted to bring to the attention of the Task Force. St. Joseph's advocates and supports the current system of Certificate of Need, and also the array of medical services that are covered by Certificate of Need review. St. Joseph Medical Center is in full support of MHA's recommendations.

Mr. Flanagan noted the general observation or belief that Certificate of Need somehow eliminates all competition. He suggested that Maryland hospitals could, in consultation with the Maryland Hospital Association, develop some type of barometer, a set of indicators that could regularly determine if this effect is really occurring. St. Joseph's own observation is that Central Maryland, in particular, is one of the more highly competitive hospital industry areas in the country, and this fact makes the statement that Certificate of Need precludes a competitive marketplace a fallacy.

### 15. Nicole Price, SEIU, District 1199 E-DC

Ms. Price, Political Organizer for SEIU, District 1199 E-DC, testified on behalf of the 10,000 health care workers represented by SEIU and of consumers of health care, commending the Task Force for allowing public input in this process. SEIU believes that the citizen involvement inherent in the Certificate of Need process assures that consumers have a voice in the quality of health care provided in our community. Certificate of Need

provides for greater accountability, more fiscal responsibility, and ultimately equity, in assessing and addressing the need for health care services. Access to health care is important to Maryland working families and health care workers in the community, who believe that the Certificate of Need process is extremely valuable in their quest to provide the best health care services in their communities. The rising cost of health care is a huge problem that negatively affects many people in our state on a daily basis. As health care costs continue to skyrocket, the need for consumer protection becomes even more vital. Expansion of health care services must be done in a thoughtful manner that considers the overall health care needs of the community.

Ms. Price stated SEIU's belief that the Certificate of Need process plays an integral role in protecting and promoting access to quality health care for all Marylanders. It creates a rational allocation of health care resources to ensure that the public needs are being met in the most effective manner. The process lowers costs by avoiding duplication of services, and efficiently distributing services across the state. Too often, she said, expansion of services without regard to the need to do so does little to enhance the delivery of health care services to Marylanders in our more affluent communities, but it costs many dollars that could have been used to ensure proper, necessary health care services to people who do not have them in poor communities today. Without Certificate of Need, SEIU believes that we risk losing vital health care services in low income areas.

Ms. Price said that the current Certificate of Need process in Maryland assists in assuring that the playing field is leveled for indigent care, thereby reducing to the same degree cost shifting to the insured population. With the high cost of health care forcing many working Marylanders to lose health care coverage, SEIU believes that we need a state policy that assures effective allocation of health care dollars and services in our state. A strong Certificate of Need process is vital for many basic reasons. We cannot predict our health, and when we may need hospital care. Patients do not have the same information that physicians and hospitals have about where to receive the best quality of service. With greater advances in health care technology, health care costs continue to rise and access to technology is not available to all communities. The Certificate of Need process protects vulnerable populations from a loss of health care services. For all of these reasons, SEIU believes that the Certificate of Need process is needed, as well as other oversight opportunities for the public in legislative review and public hearings to review and evaluate whether the local health systems are meeting the needs of everyone.

Ms. Price reported that states that have eliminated Certificate of Need laws have seen a proliferation of physician-owned specialty hospitals that do not provide uncompensated care, and do not have twenty-four hour ER services. These states have more hospitals offering high-profit services such as heart bypass surgery. This can reduce the quality of bypass surgery and other procedures if the hospital does not perform enough of the procedures to achieve and maintain volume. In Arizona, where the legislature deregulated Certificate of Need in 1980, nursing home capacity doubled in less than five years, while occupancy rates declined to less than 75%. In Utah, where Certificate of Need was deregulated in 1984, psychiatric bed capacity increased so much that major employers retaliated by reducing mental health benefits. Other states, such as

Wisconsin, Georgia, and Virginia, have all concluded that the Certificate of Need process assures quality and the equitable distribution of health care services. In Maryland, as well as across the country, hospitals have merged into large systems, and insurers are merging with each other and converting to for-profit status. These trends suggest to SEIU that Certificate of Need is more important than ever, to preserve public confidence in the quality of health care. SEIU believes that Maryland should retain Certificate of Need regulation to protect access to quality, affordable, secure health care. SEIU 1199 E-DC strongly supports Maryland's Certificate of Need program. As key stakeholders, they are committed to serving the public's interest by promoting access, oversight, and accountability. They welcome the opportunity to work with the Task Force to enhance quality and affordable health care for all Marylanders.

Task Force member Dr. Hussein said she agrees with the statement that the Certificate of Need process is particularly important to maintaining quality of services for vulnerable populations. Dr. Hussein observed that Maryland has some of the best health care facilities in the nation but that minority health care disparities continue here as well as elsewhere; she asked if SEIU could offer specific suggestions as to how the Certificate of Need process can help increase access to quality services. Ms. Price said that her organization would submit written testimony which will include some of those suggestions. Ms. Bonde asked Ms. Price to include the data that she cited about changes to health care access in states that had eliminated Certificate of Need with SEIU's written comments, which she agreed to do.

### 16. Thomas Firey, Maryland Public Policy Institute

Mr. Firey began by asking the Task Force – whose mandate is to find ways to modify and enhance the Certificate of Need process – to consider instead whether the Certificate of Need program works at all. Mr. Firey said that there has been no empirical analysis in Maryland of that question, of whether Certificate of Need holds down costs, or improves the quality, of the health care services regulated under the program.

Mr. Firey stated that there are two competing theories about Certificate of Need. One theory takes the view that the immense, initial fixed costs of building and equipping health care facilities and establishing new health care services must be paid regardless of how many consumers use them, and that too much supply – too many expensive buildings, duplicated equipment, scarcer staff commanding higher salaries – results in higher costs, since the initial investments must be repaid. The Maryland Health Care Commission, ideally, uses Certificate of Need to examine proposed buildings and programs, to determine if they are necessary, in order to try to reduce fixed costs, and therefore hold down the price of the services to consumers of health care.

The opposing theory is market economics, which holds that market forces operating in a free and unfettered environment lead to the most efficient provision of services and goods, including health care. Under market theory, Certificate of Need is actually a danger to the consumer because any commission, any central planning

authority, brings with it risks for insufficient information, administrative delay, and a tendency to protect certain provider interests.

Mr. Firey noted that considerable academic research has been focused on Certificate of Need in the past quarter-century, much of it conducted during the early 1980s, after the Reagan Administration announced its intention to end the federally-mandated Certificate of Need program, and leave to the states the decision of whether or not they would continue the program. An early evaluation of the effectiveness of the federally-defined Certificate of Need program was that by Frank Sloan of Duke University, writing in the *Review of Economics and Statistics* and in the *Milbank Quarterly*. Sloan examined states that had complied with the federal mandate and states that had not, and he did a statistical analysis showing no statistical relationship between an active Certificate of Need program and lower overall health care costs. Seven other academic studies published in the early to mid-1980s arrived at the same basic conclusion: that Certificate of Need programs did not act to hold down health care costs.

Other studies of approximately the same period found that Certificate of Need was actually statistically linked to higher hospital prices and profits. Several states had dropped their CON laws by the time repeal of the federal program took effect on October 1, 1987, and others subsequently repealed their programs, or changed their scope. Consistent with the studies published at about this time was the conclusion that Certificate of Need laws, over time, resulted in higher hospital profits, by 15 to 25%, and hospital costs approximately 20% higher than in states without a Certificate of Need program.

Mr. Firey stated that similar research has examined the effectiveness of Certificate of Need programs in controlling Medical Assistance budgets, by limiting the supply – and consequently controlling the demand – for nursing home beds. Ohsfeldt, Morrisey, and Grabowski, in the journal *Inquiry,* found that neither CON requirements for nursing homes, nor moratoria on nursing home construction have any statistical effect on Medicaid expenditure. In general, the research has shown that Certificate of Need does not accomplish its often-stated purpose of holding down health care costs and charges.

Mr. Firey suggested that Certificate of Need programs are successful at protecting existing providers, and that anti-competitive risks are inherent in acting to control the supply of health care providers, and thereby restricting the free choice of consumers of care. The Anti-Trust Division of the Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") focused on that aspect of Certificate of Need programs in their joint 2004 report, *Improving Health Care: A Dose of Competition,*" in which these agencies concluded that ". . . CON programs are generally not successful at containing health care costs. They can pose anti-competitive risks. As noted [in the report], CON programs risk entrenching oligopolists and eroding consumer welfare. Controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anti-competitive risks. A similar analysis applies to the use of CON programs for health care quality and access. For these reasons, the agencies [DOJ and FTC] urge states with CON programs to reconsider whether they are best serving their

citizens' health care needs, by allowing these programs to continue." In Maryland, the Maryland Public Policy Institute's recent publication *"Health Care in Maryland: A Diagnosis"* contains a chapter by Michael A. Morrisey that shares this view of the impact of Certificate of Need programs on hospital costs and charges; Mr. Firey provided a copy of this publication to the Task Force.

Task Force member Michelle Mahan asked Mr. Firey how, in his research, he accounted for the nature of Maryland's unique system of hospital regulation, which includes the nation's last all-payer rate-setting program with a waiver from the Medicare prospective payment system, administered by the Health Services Cost Review Commission. Mr. Firey said that he would re-examine the available data and do some Maryland-specific research; he was unclear about how the dynamics between HSCRC and the Certificate of Need program worked.

Task Force member Joel Suldan asked Mr. Firey if he would change his views on the Certificate of Need program if he knew that – through the interaction of the Certificate of Need and the hospital rate-setting system – Maryland's hospital profits and its increases in costs per case for inpatient care over twenty years have both remained lower than those of the nation as a whole? Mr. Firey responded that his view of the program would not change

Mr. Rosen asked about the Maryland Public Policy Institute, specifically with respect to the size of its staff. Mr. Firey replied that MPPI is a very small public policy group, with four staff members—two full time and two part time people—operating out of Germantown.

**3. Closing Comments and Adjournment**

Chairman Nicolay asked whether two persons on the sign-up sheet had arrived; they had not. He then asked if anyone else present wished to testify; no one else came forward. Chairman Nicolay congratulated and thanked all who presented comment to the Task Force, and asked for a motion to adjourn. Upon the motion of Commissioner Moffit and a second by Task Force member Jack C. Tranter, the Chairman adjourned the Public Forum at 12:28 p.m.